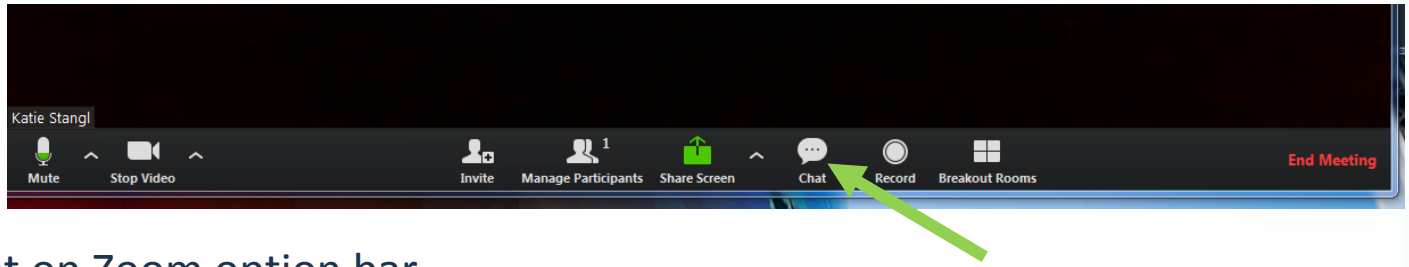
Opioid Review and MAT Clinic
CDC Guidelines

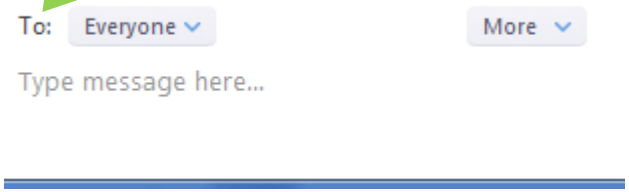
January 10, 2018

Housekeeping

- Use chat feature to inform everyone who's at your clinic



- Click chat on Zoom option bar
- Chat "Everyone" the names of those who are in your room and the city you are in.



- National Rx Drug Abuse and Heroin Summit
  - Atlanta, Georgia from April 2-5
  - https://vendome.swoogo.com/2018-rx-summit/

"It takes courage to let go of the familiar and embrace the new."

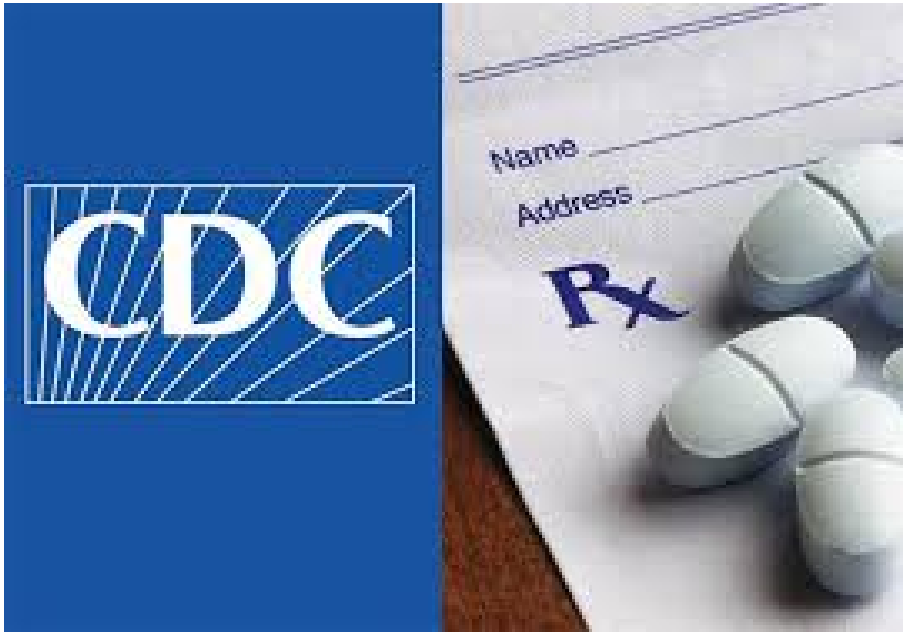
- Alan Cohen

CDC Guidelines Objectives

- Demonstrate understanding of CDC guidelines
- Recognize the risk of escalated opioid dose with simultaneous benzodiazepine use or comorbidities

CDC Guidelines

- The recommendations in these guidelines are voluntary



Background

- Chronic pain … typically lasts > 3 months or past the time of normal tissue healing (*5*).
- Evidence supports short-term efficacy of opioids for reducing pain and improving function in non-cancer nociceptive and neuropathic pain in randomized clinical trials lasting primarily ≤ 12 weeks (*9,10).*
- Few studies have been conducted to rigorously assess the long-term benefits of opioids for chronic pain (pain lasting > 3 months) with outcomes examined at least 1 year later (*14*).

Background

- Tolerance – diminished response to a drug with repeated use and physical dependence.
- Dependence- physical condition in which the body has adapted to the presence of a drug and causes physical ill effects when the drug is removed.
- Addiction- an uncontrollable or overwhelming need to use a substance, and this compulsion is long-lasting and can return unexpectedly after a period of improvement.

Background

- Use of prescribed opioid pain medication before high school graduation is associated with a 33% increase in the risk of later opioid misuse (*41*). Misuse of opioid medications in adolescence strongly predicts later onset of heroin use *(42)*.
- One in 32 patients who escalated to opioid dosages > 200 morphine milligram equivalents (MME) died from opioid-related overdose (*25*).

Guideline Development Methods

- Grading of Recommendations Assessment, Development and Evaluation (GRADE) method
  - Type 1 evidence (randomized clinical trials or overwhelming evidence from observational studies)
  - Type 2 evidence (randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies)
  - Type 3 evidence (observational studies or randomized clinical trials with notable limitations)
  - Type 4 evidence (clinical experience and observations)

Summary of Findings of Clinical Questions

- Evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited
- Based on randomized trials predominantly ≤12 weeks in duration, opioids were found to be moderately effective for pain relief

Summary of Findings of Clinical Questions

- Evidence suggests risk for serious harms that appears to be dose-dependent
- Factors associated with increased risk for misuse included history of substance use disorder, younger age, major depression, and use of psychotropic medications (*55*,*62*).

Opioid Dosing Strategies

- One new fair-quality cohort study of Veterans Affairs patients found initiation of therapy with an ER/LA opioid associated with greater risk for nonfatal overdose than initiation with an immediate-release opioid, with risk greatest in the first 2 weeks after initiation of treatment (*77*).

Risk Assessment (Type 3)

- Results for the Opioid Risk Tool (ORT) (*89–91*) were extremely inconsistent
- No study evaluated the effectiveness of risk mitigation strategies for improving outcomes related to overdose, addiction, abuse, or misuse.
  1. Use of risk assessment instruments
  2. Opioid management plans
  3. Patient education
  4. Urine drug testing
  5. Use of PDMP data
  6. Use of monitoring instruments
  7. More frequent monitoring intervals
  8. Pill counts
  9. Use of abuse-deterrent formulations

Summary of Findings for Contextual Areas

Effectiveness of Nonpharmacologic and Nonopioid Pharmacologic Treatments

Several nonpharmacologic and nonopioid pharmacologic treatments have been shown to be effective in managing chronic pain:

1. *CBT*
2. *Exercise Therapy*
3. *Multimodal and multidisciplinary therapies*
4. *Acetaminophen*
5. *NSAIDs*
6. Cyclooxygenase 2 (COX-2) inhibitors
7. Selected anticonvulsants
8. Selected antidepressants

Benefits and Harms of Opioid Therapy

- Methadone has been associated with disproportionate numbers of overdose deaths relative to the frequency with which it is prescribed for pain. Methadone has been found to account for as much as a third of opioid-related overdose deaths involving single or multiple drugs in states that participated in the Drug Abuse Warning Network.
- Despite representing < 2% of opioid prescriptions.

Benefits and Harms of Opioid Therapy

- Prescription opioid-related overdose mortality rates rose rapidly up to prescribed doses of 200 MME/day.
- Three studies of fatal overdose deaths found evidence of concurrent benzodiazepine use in 31%–61% of decedents (*67*,*128*,*129*).

Benefits and Harms of Opioid Therapy

- Regarding duration of use, patients can experience tolerance and loss of effectiveness of opioids over time (*130*). Patients who do not experience clinically meaningful pain relief early in treatment (i.e., within 1 month) are unlikely to experience pain relief with longer-term use (*131*).

Benefits and Harms of Opioid Therapy

- Populations potentially at greater risk for harm:
  - Patients with sleep apnea
  - Patients with renal or hepatic insufficiency
  - Older adults
  - Pregnant women
  - Patients with depression or other mental health conditions
  - Patients with alcohol or other substance use disorders

Benefits and Harms of Opioid Therapy

- No studies were found to examine prescribing of naloxone with opioid pain medication in primary care settings, naloxone distribution through community-based programs providing prevention services for substance users has been demonstrated to be associated with decreased risk for opioid overdose death at the community level (*147*).

Benefits and Harms of Opioid Therapy

- Concerns have been raised that prescribing changes such as dose reduction might be associated with unintended negative consequences, such as patients seeking heroin or other illicitly obtained opioids (*148*) or interference with appropriate pain treatment (*149*). CDC did not identify studies evaluating these potential outcomes.

Benefits and Harms of Opioid Therapy

- Regarding the effectiveness of opioid use disorder treatments, methadone and buprenorphine for opioid use disorder have been found to increase retention in treatment and to decrease illicit opioid use among patients with opioid use disorder involving heroin (*151–153*).
- Effectiveness is enhanced when psychosocial treatments are used in conjunction with medication-assisted therapy.

Links

CDC Guidelines Summary

References

CDC Guidelines

- When to initiate/continue opioids for chronic pain
  - Non opioid treatment is preferred, use opioid if benefits outweigh risks
  - Establish treatment goals: only if meaningful improvement in pain and function
  - Before and during: discuss risks and benefits

CDC Guidelines

- Opioid selection/dosage/duration/FM/DC
  - Immediate release
  - Lowest effective dose
    - Decreases benefit, increases risk when > 50 MME
    - Avoid or justify ≥ 90 MME
  - Chronic starts with acute. In acute, use lowest effective dose with immediate release
  - Rarely go > 7 days

CDC Guidelines

- Assessing Risk and Harms
  - Evaluate for opioid related harms and give naloxone- h/o OD, h/o SUD, > 90 MME, and benzodiazepine
  - Review PDMP for other opioids or risk benzodiazepine
  - UDAS at start and min. annual for prescriptions and others
  - Avoid opioids with benzodiazepine
  - MAT with mental health evaluation for OUD

MN State Guidelines

- Most important= safety of patients if on C.O.A.T. (Chronic Opioid Analgesic Therapy)
  - DC if possible
  - Or, decrease to 50 MME
- Goals
  - Functional improvement
  - Active pain management
  - Multimodal treatment

Management

- Functional status, not achieving no pain
- Biopsychosocial assessment
- Rx goals- function and quality of life, not resolution of pain
- Active participation- document physical limitations
- Care coordination- 1 pharmacy
- Provider agreement
- < 50 MME, never > 90 MME
  - Document that you spoke with the patients about the risks and benefits
- Write one month scripts that will not run out on weekends, meet face to face once every three months
- Offer to taper each visit
- Avoid chronic opioid treatment in patients with SUD

Formulation

- Short acting IR
- Avoid substitution without looking at conversion table
- Avoid Methadone unless physician has additional training
- Caution with Fentanyl

Risk Mitigation/Safety

- UDS prior to opioids
- Consider random 2x per year (US. 1/CDC)
- Pill counts (24 hours to get to clinic)
- Screen for opioid use disorder
  - Hints? Drug seeking behavior?
- Early consultation to help identify the potential for increased risks (or shouldn't that be our job)

Clinical Recommendations

1. Prior MH evaluation- before start
2. Establish treatment goals
    1. Functional improvement
    2. Quality of life
    3. NOT resolution of pain
3. Barriers to active participation in treatment
4. Have care coordination
5. Controlled substance care agreement (pain contract)
6. Lowest possible dose
    1. Comorbidities
    2. > 90 document why/risk benefit

Clinical Recommendations

7. Treatment
8. Consider taper or DC at all visits
9. Avoid with substance abuse history
10. Do not start with long acting
11. Only doctors trained or experienced should use Methadone for chronic pain
12. Avoid Fentanyl for pain, increase risk of diversion and harm

Discussion

- Pain intensity scores not helpful
- Confirm origin of pain
- Consider possibility of opioid induced hyperalgesia
- Consider opioid induced pain by adaptation
- PP Agreement- consistent enforcement
- > 90 ME should be considered temporary
- 50 should likely be goal when harm vs. benefit considered
- Studies suggest increase risk of death when ER/LA used vs. starting short acting

Discussion

- Methadone
  - Increase ½ life, not consistent
  - Respiratory depression last longer than analgesia
  - Reserved for small subset
- Fentanyl
  - Not used with other long acting
  - Never use in patients with history of substance use disorder

Discussion

- Screening for opioid use disorder
  - Approximately 25% with chronic pain have

- MAT
  - Buprenorphine- waiver
  - Methadone- federal licensure
  - IM Naltrexone

MN State Guidelines